TREATING PSYCHOLOGICAL TRAUMA AND PTSD

Edited by

John P. Wilson
Matthew J. Friedman
Jacob D. Lindy

THE GUILFORD PRESS
New York London

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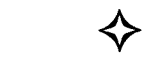
Group Psychotherapy for PTSD



DAVID W. FOY, PAULA P. SCHNURR, DANIEL S. WEISS, MELISSA S. WATTENBERG, SHIRLEY M. GLYNN, CHARLES R. MARMAR, and FRED D. GUSMAN

In this chapter we present an overview of three types of group therapy—supportive, psychodynamic, and cognitive-behavioral—currently used in the treatment of posttraumatic stress disorder (PTSD). Preliminarily, the historical development of group treatment for PTSD is briefly reviewed, including several advantages offered by group therapy, followed by an overview of evidence providing empirical support for group treatment. Next, for each type of group therapy the treatment rationale and description of procedures are presented, along with a case example. Considerations for offering group therapy as a primary mode of therapy are enumerated. Finally, we discuss matching criteria for use in selecting the type of group intervention that best fits a particular client, and areas of necessary further investigation are identified.

HISTORICAL DEVELOPMENT OF GROUP TREATMENT FOR PTSD

Chronic PTSD typically involves a disruption of trust in others (Janoff-Bulman & Frieze, 1983; McCann & Pearlman, 1990). By their very nature, many traumatic experiences involve interpersonal violence (e.g., rape, physical assault, domestic violence, torture, or combat) and incorporate at their

core information about how humans are capable of harming other humans. Other traumas, especially those resulting from natural disasters or accidents, may not involve interpersonal violence per se but often include responses of fear, helplessness, or horror. These emotions may cause survivors to question whether others are really available to assist and support them in times of extreme need, and result in a subsequent disruption of trust. The disruption in trust seen in trauma survivors is reflected in the DSM-IV PTSD avoidance symptom, "feeling of detachment or estrangement from others."

Given the prominence of disturbances in trust in the responses of trauma survivors, it is not surprising that *group* treatment of traumatic responses has been a common form of intervention. The appeal of group interventions for PTSD rests, to a large extent, on the clear relevance of joining with others in therapeutic work when coping with a disorder marked by isolation, alienation, and diminished feelings (Allen & Bloom, 1994). A group intervention seems even more suitable for populations such as Vietnam veterans or sexual assault survivors, who often feel ostracized from the larger society, or even judged and blamed for their predicament. Bonding with similar others in a supportive environment can be a critical to regaining trust. Beyond its obvious cost advantage, group therapy may be particularly useful for those individuals who fail to meet common assumptions (e.g., psychological mindedness and responsibility for life choices and outcomes) thought necessary for individual psychotherapy (Klein & Schermer, 2000).

Inherent in the earliest forms of group intervention for PTSD was the notion that survivors must rely on other survivors, often without benefit of professional assistance (Brende, 1981). Veterans' groups and women's groups were often left to address trauma issues with little professional input or guidance. In part, this emphasis on self-help reflected the lack of clear PTSD diagnostic criteria offered by professional organizations such as the American Psychiatric Association or the American Psychological Association during the 1960s and 1970s. In addition, it probably also reflects many survivors' general distrust of other people, especially those who have never been traumatized. It is not at all surprising that, among these individuals who felt alienated from and distrust of the greater community, group interventions originally tended to adopt a "survivor helping survivor" or "band of sisters/brothers" model in which the group facilitator(s), in fact, shared the same traumatic exposure history as those seeking counseling (Lifton, 1973; Shatan, 1973). These interventions emphasized communality and mutual commitment—in short, the engendering of trust. The genesis of veterans' "rap groups" and the creation of the VA (Veterans Administration) Readjustment Counseling Service, in which Vietnam veterans were hired to assist other veterans outside of the traditional hospital setting, epitomizes this type of approach.

While groups of survivors assisting and witnessing for each other have often offered participants comfort and support, there have been no controlled

trials to establish an empirical basis for their efficacy in promoting recovery from traumatic events. In contrast, mental health professionals from several theoretical orientations have refined and tested a number of more systematic group interventions for PTSD since its inclusion in the psychiatric nomenclature in 1980. In contrast to rap groups, these interventions hold to clearly delineated lines between the therapist and clients, and are intended for group members who share a specific, well-diagnosed, acknowledged psychiatric disorder. Some have argued that they are especially appropriate for more chronic forms of PTSD (Walker & Nash, 1981).

In surveying the scientific literature on types of group therapy for PTSD, distinctions can be drawn between "covering" and "uncovering" methods utilized to address the traumatic experiences of members. *Supportive groups* represent a "covering" approach in which the emphasis is placed on addressing current life issues, whereas *psychodynamic* and *cognitive-behavioral* approaches are designed to address members' specific traumatic experiences and memories directly (i.e., "uncover" the trauma). In fact, current group treatments from either psychodynamic or cognitive-behavioral perspectives are often described as "trauma focus" groups wherein members' recounting of their traumatic experiences is a primary feature. Trauma focus groups of either type are more likely to be conducted as "closed" (or cohort) groups, while supportive groups are amenable to an "open" format in which members can be added after the group begins. Some clinicians have posited that a combination of approaches, tailored to the individual's specific phase of the disorder and clinical status, may be most appropriate (e.g., Herman, 1992).

The theoretical contributions of Yalom's (1995) principles of group process to the conduct of each of the three types of trauma group treatment have often been acknowledged (e.g., the importance of the instillation of hope). Nevertheless, it is imperative to note that none of these approaches is "process oriented" strictly defined. That is, the critical therapeutic ingredient is *not* thought to be the corrective recapitulation of the primary family group nor expression of intense affect between members about their relationship. While they may differ in their underlying formulations of symptom etiology and maintenance, these three approaches share some basic features: (1) homogeneous membership in the group by survivors of the same type of trauma (e.g., combat veterans or sexual assault survivors); (2) acknowledgment and validation of the traumatic exposure; (3) normalization of traumatic responses; (4) utilization of the presence of other individuals with a similar traumatic history to dispel the notion that the therapist cannot be helpful to the survivors because he or she has not shared the experience; and (5) adoption of a nonjudgmental stance toward behavior required for survival at the time of the trauma. Incorporating these principles facilitates the development of a psychologically safe, respectful therapeutic environment which permits members to address issues of trust.

EVIDENCE SUPPORTING GROUP THERAPY

Recently, we have reviewed in detail the published reports of clinical trials of group psychotherapy for adult trauma survivors (Foy et al., 2000). We found that group therapy was typically conducted over 10–15 weekly sessions (range = 6 weeks to 1 year), and session length was usually set at 1½ or 2 hours. Most studies were conducted with female survivors of childhood or adulthood sexual abuse; very few published reports have included male participants.

Overall, the current literature provides consistent evidence that group psychotherapy, regardless of the type, is associated with favorable outcomes across a number of symptoms. PTSD and depression are the most commonly targeted, but efficacy has been demonstrated for a range of other symptoms as well, including global distress, dissociation, self-esteem, and fear. Elsewhere we have delineated a number of significant methodological issues—including random assignment of participants, ensuring adequate statistical power, and use of standardized treatment manuals—that currently constrain the causal inferences that can be drawn about the efficacy of group treatment (Foy et al., 2000). These limitations are particularly important for informing future research in this area. In the next sections we offer a treatment rationale and description of procedures in some detail for each of the three types of group treatment. Further, to illustrate the application of these group treatments, case illustrations are offered for the three treatments.

SUPPORTIVE GROUP PSYCHOTHERAPY

Rationale

The supportive tradition stems largely from the humanistic and experiential movements in psychotherapy. These movements suggest a natural healing process that occurs through actively experiencing interpersonal contact in the present, in an atmosphere of acceptance and emotional safety. In group therapy, "the whole is greater than the sum of its parts," taking on a life of its own beyond that of the individual members within it. Participation in this powerful environment can enhance and accelerate progress toward emotional health. Schema theory (McCann & Pearlman, 1990; Neisser, 1976), often applied to understanding the alteration of cognitions in PTSD, similarly suggests that healthy cognitive schemas automatically incorporate new information, flexibly recalibrating and reorienting toward optimal adjustment in the current environment. For individuals with PTSD, trauma-based intrusions, affects, and attitudes interfere with this automatic process of digesting and assessing new information (Zlotnick et al., 1997). Therapy which provides consistent access and attention to the current environment will allow mem-

bers' trauma-influenced worldviews to gradually readjust, resulting in healthier functioning. From this perspective, supportive group therapy may offer a corrective context in which to modify the effects of trauma.

As in any therapy, clients with PTSD may be reluctant to give up patterns learned in the interest of survival under traumatic conditions of threat and danger. A pseudomutual, premature cohesion (Parson, 1985) can develop in groups, one in which group members validate each others trauma-based attitudes while dismissing the value of change. The symptoms and features of PTSD can also present challenges to group treatment (e.g., difficulty verbalizing feelings, distrust of authority, control issues, hyperarousal, and distracting intrusions). Supportive group therapy for PTSD addresses these issues in a number of ways. The active therapist style and moderate structure assists in diffusing a countertherapeutic stance. Groups often include segments of psychoeducational discussion on PTSD which validate the potentially interfering symptoms while asserting that these issues are grist for the (therapeutic) mill. And the therapeutic factors offered by supportive group therapy (e.g., universality, interpersonal learning, development of social skills, cohesion, and containment) can offer particular advantages for PTSD treatment.

Description

Supportive group therapy for PTSD is problem oriented, providing members with additional social support in the group to improve current coping. Groups may differ in their theoretical underpinnings, but they do share some characteristic features. Supportive groups typically avoid actual details of members' traumatic experiences, although personal consequences of trauma are acknowledged and validated. Groups are managed so that there is some emotional engagement of members' middle-range affects (e.g., frustration, sadness, happiness, or hurt), while rage and terror are diffused. Supportive groups infrequently use structured materials, and expectations for members' participation rarely involve homework or testing for mastery of material. Unlike Tavistock-style experiential groups, supportive groups attempt to maintain a sense of interpersonal comfort and to keep transference at a low-to-moderate level. Other features of supportive groups include an active, facilitative leadership style, emphasis on members' strengths, process-encouraging interventions, combination of pragmatic and "here-and-now" focus, low-to-moderate structure, and view of change as gradual and incremental. Level of confrontation is generally low to moderate.

Chronic PTSD often interferes with responses to current circumstances and may lead to gradual deterioration in functioning. Intrinsic therapeutic factors found in group psychotherapy (Yalom, 1995) help mobilize the personal resources of group members, thereby helping to control interference from symptoms and trauma-based attitudes, as reflected in social, emotional, occupational, and recreational functioning. Supportive groups are used in a

variety of settings to promote a sense of community among "fellow strugglers" dealing with isolating chronic conditions and circumstances. These include crisis intervention (e.g., for divorce, job loss, recent rape or other victimization), adjustment to life transition (e.g., retirement), and stabilization of an acute or exacerbated condition (e.g., following psychiatric hospitalization). In PTSD programs, supportive groups may serve as a primary therapy modality, or they may provide support and preparation for other therapies. In many programs for PTSD, supportive groups help members positively participate in their overall treatment, providing cohesion and comfort for coping with more demanding therapies.

Case Example

The group, facilitated by two cotherapists, offered supportive, present-focused psychotherapy for a homogeneous, closed cohort of six Vietnam combat veterans with PTSD. Running for 30 weekly sessions and 5 monthly follow-up sessions, it featured orientation, psychoeducation, and goal-setting in the first four sessions, and open current-day discussion in the remaining sessions. The client, Sam, a 50-year-old, service-connected Army veteran with combat-related PTSD secondary to two tours in Vietnam, had just returned to live with his wife and 15-year-old daughter, after a series of separations. His presenting problems included intrusive recollections, sleep loss, nightmares, irritability, depression, occasional flashbacks, emotional numbing, alexithymia, panic disorder, mild agoraphobia, isolation, depression, poor concentration, intermittent self-medication with alcohol, and family problems.

Case History

Sam described a "happy" early family, school, and social adjustment. Drafted in 1966, he "did well" in the military prior to going to Vietnam. He completed two tours in Vietnam, spending most of 18 months "in the bush." Traumatic events included being ambushed twice on patrols, seeing a buddy killed in front of him, engaging in "body counts," and witnessing deaths of civilians during two incursions into villages. He recalls experiencing his first PTSD symptoms toward the end of his second tour, exacerbated on return to the United States by unreceptive "homecoming" experiences. Drinking heavily, experiencing flashbacks and sleep disturbance, and oscillating between suicidal and homicidal urges, he was hospitalized for psychiatric treatment within a couple months after discharge, receiving a diagnosis at that time of "schizophrenia, paranoid type" (prior to recognition of PTSD diagnosis). He left treatment upon release, coping through avoidance, numbing, and alcohol use. He walked away in anger from a variety of jobs and now has not worked for 20 years.

Case Formulation

Reexperiencing, hyperarousal, and avoidance of intimacy had limited Sam's postcombat functioning. His Vietnam experiences contributed to his difficulty in maintaining a consistent family life. His distressing homecoming from Vietnam, aversive early treatment experiences, and subsequent avoidance of treatment all suggested a need for supportive therapy.

Course of Treatment

Beginning Phase of Group: *Group Forming/Setting Norms (Sessions 1–7).* Sam initially responded more to the male facilitator (a Vietnam veteran) than to the female facilitator. He often appeared distracted in group and reported, "I'm having more nightmares, not sleeping—my wife wonders if this is right for me—is this supposed to happen?" Facilitators helped the group understand that the group itself could be a "trigger" initially and that comfort was likely to increase as members got to know each other. Sam occasionally made abrupt, disconnected trauma references; facilitators helped him identify these as resulting from intrusive recollections and encouraged refocusing on the present. In early discussion of family issues, Sam joined with members about how family members "push their buttons." During the fifth group, Sam departed from the group norms by leaving early, without explanation. After missing the sixth session, he returned and explained, "I had an argument with my daughter. She was writing a report on Laos for her history class—well, I was in Laos, so I tried to help her. She wouldn't listen—she kept saying, 'Never mind, Dad, never mind!' Then she wanted me to check her spelling, and I blew up! My wife took her side. I didn't sleep all night, and when I came to group, somebody else was talking; and I didn't want to interrupt . . . I know I shouldn't have left . . . I started drinking on my way home . . . I was embarrassed to come to group last week." Facilitators helped the group consider the impact of intrusive memories and hyperarousal (triggered by the topic of Laos) on Sam's reaction to his family. Group members shared similar experiences, suggested coping strategies, and recommended Alcoholics Anonymous (AA). Sam was receptive but made "no guarantees."

Middle Phase of Group: *Cohesion (Sessions 8–16).* Sam discussed the fear, anger, and shame he experienced in his early contact with the VA, which he initially associated with the group and with the female facilitator. He identified more with other members ("We're all in the same boat") and directed comments toward them rather than toward the facilitators. He began to confront members if they missed a group (as members started to "own" group norms) but uniformly supported his peers in their interactions with people outside the group.

Later Phase of Group: *Awareness and Changes (Sessions 17–24).* Sam and other members began to actively confront each others' contributions to problems in personal and family relationships ("Sounds like it's 'your way or the highway'!"). By week 19, Sam announced that he hadn't had a drink in 2 months. His occasional trauma references were connected to current issues (e.g., "It's hard for me to get close to people now, because of the way I lost my buddy"). At the group's urging, Sam explained his actions and needs more clearly to his family, in place of yelling, intimidating, or projecting a stony silence. Group members encouraged Sam to accompany his family on a vacation—an activity he had avoided in previous years. The group helped him problem-solve how to manage his hyperarousal during the trip, and he returned reporting success.

Ending Phase of Group: *Consolidation (Sessions 25–30, and Monthly Follow-Up Sessions 1–5).* As the group neared the end of its weekly sessions, members revealed more personal issues. Sam described the drinking and outbursts of temper that led to years of alienation from his family. On the group's advice, he talked with his daughter about how his PTSD had affected him through the years and reassured her that it wasn't her fault. As the group terminated, he articulated a relationship between leave-taking in group and in Vietnam: "Back then, we said, 'It don't mean nothing,' and moved on. But now, I can carry the spirit of the group with me."

Outcome

Sam's initial increase in symptoms abated within 8 weeks, at which point he also appeared significantly less depressed. He spoke less about symptoms and more about positive efforts in his life. As group continued, he was able to join his family on vacations for the first time in years. He and his wife remained together throughout the period of the group and beyond—a longer period than they had experienced over the past 3 years. He was able to assert himself in group and with family members. Sam and other members moved from blaming their wives and other family members to acknowledging their own contributions to family problems. Sam himself expressed surprise at "how fast I've been making these changes," and he attributed this ability to the group.

Conclusions

Sam needed to address the confusing and shaming experiences from his early treatment in order to establish comfort with current treatment. His motivation to address this difficult issue developed from his wish to connect with other group members. As the group offered normalization and demystifica-

tion of symptoms, problem solving, and practice attending to present-day environment and current feelings, Sam partially modified the worldview and automatic responses derived from his combat experiences in Vietnam. Changes were at first more evident within in the group than outside the group but eventually generalized to important family relationships. By the end of the weekly sessions, Sam reported, "My symptoms are still there, but they don't get in the way as much."

PSYCHODYNAMIC GROUP THERAPY

Rationale

The primary goal of psychodynamic group therapy for PTSD is to help members achieve new understanding of their traumatic experiences, their own reactions at the time, and continuing related psychological issues. The group seeks to help each member clarify his or her working model of self and other(s) involved in reactions to his or her traumatic events. Among these clarifications are cognitive appraisals of internal dialogues about the meaning of the event, "lessons learned," or personal meaning attributed to an event or some aspect of the event. Group process includes exploring members' conscious and unconscious self-concepts related to self-representations evoked by their traumas. These trauma-related self-representations are then related to current conflicted views of the self, and to self-representations from early development. In addition, clarification of common implicit assumptions about predictability and culpability involved in the meaning of the trauma is made in the safe context provided by the group.

Psychodynamic group therapy promotes integration of accurate recounting of events, including pre- and posttrauma issues that are important parts of each member's story. These important aspects include responses by family members and others in the trauma social milieu. Members' affective involvement is dosed to allow group work to be done without overwhelming members by precipitating dissociative reactions or flashbacks. Members' affective patterns typically involve initial anxiety prior to recounting the incident, anxiety and/or tears during the telling, and a kind of calm after the storm, when consolidation is desired. In a psychodynamic approach these painful affects are tied back to views, frequently irrational, of self and others. These irrational views may involve need for omnipotent control, the assumption that betrayal is inevitable, the belief that trauma happens only for good or understandable reason, and that avoidance of strong feelings is a necessary protective strategy.

When members are retelling their stories, recognition of the context in which the event took place (i.e., stranger vs. known assailant, use of drugs or alcohol, or ignoring of warning signs or signals) is important. During the re-

counting of stories, the leaders must be attuned to subtle but significant omissions or incongruities in members' narrations. When positive group process has developed, other members may also perform this function. Noticing and commenting upon the speaker's comments about her or his own dialogue as it unfolds is an especially important aspect of this attunement. Capitalizing upon these comments at the time and following up on their associative meanings is crucial. It is the importance attributed to these associative meanings that distinguishes the dynamic approach.

Description

Group Structure

The group should comprise five to seven members. There can be some variability among group members in basic demographics (e.g., time elapsed since trauma, age, ethnicity, or socioeconomic status). On the other hand, it will be helpful if they are homogeneous, as far as possible, regarding level of ego functioning, interpersonal skills, and ability to confront defenses and integrate warded off material.

Attempts to verify the veracity of events should tactfully be undertaken prior to a person's joining the group (e.g., law enforcement reports, medical records, and collateral information). Unfortunately, from time to time, there are individuals whose psychopathology leads them to want to become members of a specialized group, such as those being described here, when in reality they have not had the kind of experience that would qualify them. Such "as if" or "wanna-be" individuals are sometimes difficult to identify, but their inclusion in a group can be an extremely disruptive influence regarding safety and trust. Consequently, to the degree possible, the integrity of an individual's presentation should be examined carefully. Two group leaders are preferable, and one model (Weiss, Tichenor, Schadler, Marmar, & Koller, 1997) is designed to last for 24 weeks, with each session lasting an hour and a half. Various types of group can be formed (e.g., Koller, Marmar, & Kanas, 1992; Goodman & Weiss, 1998).

Overview

Sessions 1–7 are relatively structured by group leaders and initially include didactic presentation of psychoeducational material, preparation for group participation, and introduction by leaders of themes to be addressed in each session. Leaders will actively model frank discussion about disagreements or differences in viewpoints about how to proceed, appropriate supportive-probing questioning, and explicitly attend to within-group process (interpreting parallels to trauma-related issues). This structure will gradually be reduced as group members learn to take on this role. The content of sessions

8–22 will be dictated primarily by group members, but the main agenda will be repeated exposure to the traumatic event by the telling and retelling of each participant's story. Group leaders will actively direct the process as necessary and ensure that relevant themes are raised for consideration at some point during this middle trauma-focused phase. The leaders will help explicitly structure the focus of repeated tellings of the event for the individual participants, asking for concentration on affect, details, reactions, or other aspects as indicated by the participants' difficulties and what has occurred during previous tellings of the story. Sessions 23 and 24 explicitly focus on termination issues, with some increase in the activity and structuring by the leaders, as termination and treatment follow-up issues are addressed.

Group Leadership

Leaders must titrate the amount of structure and activity to simultaneously create an atmosphere of "safety" and sense of trust in their competence without unduly letting the group as a whole make important decisions and deal with issues that arise in the process. Leaders also need to allow for transference and working through of issues with authority figures if these exist. More active leadership is often necessary early in group development, though whenever it seems appropriate the leaders should solicit input and commentary from the group members themselves about the current theme, topic, story, or issue. Attention must always be paid to defensive within-group dynamics and behaviors. These defenses can be tied to avoidance and the need to regulate painful affective experiences using the language in the educational sessions of the group. These will also likely come up with respect to the safety of the group and if members can trust each other or the leaders. Countertransference issues regarding being too nice or too mean can both interfere here. In these circumstances, the other group leader must be assertive enough to comment on and redirect the discussion if the process has gone awry.

Case Example

Mr. B, was a 50-year-old Caucasian, a Vietnam veteran, with a childhood history of abandonment, violence, humiliation, and intimidation. Mr. B never met his real father and was removed from his biological mother's custody at age 4 when it was discovered that the mother's boyfriend was beating Mr. B and his two brothers. A newspaper article and photograph that Mr. B discovered as an adult documented the abuse. Mr. B's adoptive home was also abusive; his alcoholic adoptive father held a gun to Mr. B's head and threatened to shoot him, and his adoptive mother, whom he nevertheless loved, locked him in closets and hit him with lumber. During his service in Vietnam he participated in firefights and sustained shrapnel wounds. His post-Vietnam life included a stint of adequate functioning but also included

depression, volatile anger, avoidance, numb feelings, and alcoholism. He sought treatment because of his concern about his ability to father his 7-year-old son by his third wife.

Mr. B described himself as scarred by his childhood. He had a fear of crying and inability to do so, difficulty asking for help, a tendency to sabotage relationships before they caused any pain, a questioning of his identity, and homicidal revenge fantasies toward his adoptive stepfather. Any experience of affect was equated with loss of control.

Mr. B joined a group focused on the connection between childhood and traumatic events in Vietnam. He was ambivalent about committing to the group, missing half of the first 12 sessions. When present, he sat with his head down and his chair pushed back, signaling through his body language. His initial contributions to the group focused on his lethality toward others, using as examples his killings in Vietnam and his destruction of two marriages. He highlighted his self-loathing and could not imagine anyone finding him worthwhile. He believed his only peace might be death, as suggested by a story of witnessing a dying but tranquil soldier. He took the stance that distance from his wife and son was best, as he would then be sure not to hurt them. This stance was replicated in the group, and the view of himself as a potential perpetrator of violence having to be held under check by withdrawal was prominent.

Over time, Mr. B gradually revealed more of himself, prompted by the occurrence of the holidays and the memories this evoked. As his feeling of safety increased, he related incidents from both his childhood and Vietnam in which feelings of powerlessness, "being in a jungle," not knowing who was an enemy, playing survival games, and "being lied to" prevailed. During this growing attachment to the group, Mr. B developed a positive but tenuous transference to the male cotherapist. A pattern ensued that any perceived criticism or lack of attention by the "father" of the group was experienced as "being destroyed," corroding his sense of connection and self-worth. Minor slights were experienced as "slaps in the face" and triggered flashbacks of beatings and other torture. Mr. B's capacity to continue to attend the group was strained, and he considered dropping out many times. Support and feedback from other group members enabled him to recognized his distortions and appreciate how this sequence also occurred with his wife. Equally important, the ability to negotiate and be heard by the paternal figure and perceived aggressor led to replacing anger with new ways of coping after hurt feelings.

Gradually, the meaning of his childhood experiences were connected with the painful affects associated with assumptions of being loathsome as the only explanation for being victimized. During a particularly strong and painful anniversary period, Mr. B became disorganized and began to hallucinate the voice of his mother telling him to join her in death. This allowed him, however, to acknowledge his confusion about the depth of his conflicting feelings for his mother. His anger at his wife for being unavailable for his

son was helpfully interpreted as an overidentification with his son and his longing for his mother to have been available for him.

The termination of the group was difficult, since it was a loss of the group and a loss of the female cotherapist who was relocating out of state. Nonetheless, he spoke to the important changes he noted in himself and about an increased awareness of his effects on others.

COGNITIVE-BEHAVIORAL GROUP THERAPY

Rationale

Cognitive-behavioral group therapy seeks to reduce ongoing PTSD symptoms, and to enhance members' control of their symptoms when they recur. Thus, the goal of improving members' self-control and quality of life is as important as immediate symptom reduction. Recognizing that chronic PTSD frequently involves lifelong risk for symptom recurrence, cognitive-behavioral group therapy challenges members to adopt realistic goals of living fuller lives while managing risks of periodic symptom exacerbation.

Trauma processing for group members involves prolonged exposure and cognitive restructuring applied to each member's trauma story, as well as relapse prevention training to provide coping skills and resources for maintaining control over specific PTSD and related symptoms (Foy, Ruzek, Glynn, Riney, & Gusman, 1997). Repeated exposure to traumatic memories reduces trauma-related fears and desensitizes related cues. In the group, members retell their selected traumatic stories and prolonged exposure helps correct faulty perceptions of danger derived from traumatic experiences.

Some cognitive-behavioral groups are designed to help members set their traumas in a developmental perspective, taking into account the entire lifespan over pretrauma, trauma, and posttrauma time frames (e.g., Gusman et al., 1996). In these groups there is an autobiographical emphasis upon individual member's narrative construction as well as the group dynamic of having others bear witness to members' public recounting of their significant life experiences. Vicarious trauma processing may also occur through repeated exposures to the traumatic narratives of other group members. Relapse prevention planning can also be a core component of cognitive-behavioral trauma focus groups for chronic PTSD. These coping skills are useful for dealing with high-risk situations that occur during the course of group therapy, as well as after group therapy is completed.

Description

Cognitive-behavioral group treatment procedures address the need for repeated exposures to traumatic memories by devoting multiple sessions to in-

dividualized focus work on members' traumatic experiences. This extensive exposure element, along with its related cognitive restructuring (guided rethinking about the cause and meaning of the trauma), is the core treatment component. Thus, it necessarily occupies the largest percentage of the total group treatment time. It is followed by sessions teaching specific coping skills for dealing with high-risk situations that could precipitate relapse.

Table 8.1 is an example of session design and sequence of cognitive-behavioral group therapy for chronic combat-related PTSD. There are six group members and two group facilitators in each cognitive behavioral war trauma focus group. Each session is organized to include five core elements: check-in, review of homework, specific topics, assignment of homework, and check-out. There is one group meeting each week. Prolonged exposure (warzone focus) sessions last 2 hours; other meetings last 90 minutes. As outlined here, the group meets for 30 sessions, or about 7 months, followed by 5 monthly booster sessions in the clinic and 5 telephone follow-up calls.

Case Example

Mark was a 48-year-old divorced male, service-connected Vietnam veteran, referred by his VA case manager for cognitive-behavioral assessment and treatment of his chronic combat-related PTSD symptoms. His premilitary

TABLE 8.1. Cognitive-Behavioral Group Therapy: Session Topics

Introductory sessions	
Session 1	Introductions, structure, and group rules
Session 2	PTSD education
Session 3	Coping resources
Session 4	Negative and positive coping
Session 5	PTSD symptoms and self-control
Sessions 6 and 7	Premilitary autobiographies
Session 8	Prewarzone military autobiographies
Warzone focus sessions	
Sessions 9 and 10	Warzone trauma scene identification/coping review
Sessions 11–22	Warzone trauma focus
Relapse prevention and termination	
Session 23	Developmental perspective—putting the trauma in a life history
Session 24	Improving social support
Sessions 25 and 26	Anger management
Sessions 27 and 28	Risk situations and coping strategies
Session 29	PTSD rehabilitation contracting
Session 30	Summary and transition

social history was unremarkable in that there was no reported abuse, no indications of severe family dysfunction, and indications of positive school adjustment through his timely completion of high school. He served in the Marines, with training as a rifleman and supply clerk. His tour of Vietnam duty included several instances in which his unit was exposed to heavy combat and suffered casualties, although Mark himself was not wounded.

After Mark's discharge from military service, he was employed as a stock clerk in a succession of entry-level jobs, several of which he eventually walked away from after disputes with supervisors. He had had two earlier marriages, each of which produced one child with whom he had intermittent contacts, and he was there in a cohabitation relationship which began about 2 years prior to his entering group therapy. Mark had a history of three brief psychiatric hospitalizations, and he had had two extensive attempts at individual psychotherapy on an outpatient basis. He also had a history of previous alcohol abuse, but he had been sober for approximately 2 years and attended AA meetings on a monthly basis. Mark had been maintained on antidepressant medication from which there had been modest improvement in mood but no change in his PTSD symptoms. At the time of his referral he had just left his job of 8 months as a warehouseman after a disagreement with his supervisor and was reporting increased discomfort at being around other people, combat-related nightmares, and unresolved strife with his cohabitating partner.

Case Formulation

Despite Mark's positive premilitary history his postcombat adjustment had been marginal, suggesting that profound life experiences and changes in his coping capabilities occurred during his period of military service. Although his specific traumatic experiences in combat had not yet been identified, it appeared that his primary PTSD features included both reexperiencing and avoidant symptoms in the form of recurring nightmares and disrupted interpersonal relationships indicative of social isolation and mistrust. In view of his history of insignificant gains following his two previous attempts at individual therapy and his specific interpersonal difficulties, trauma-focused group therapy (TFGT) was recommended to Mark as a new form of combat-related PTSD therapy that could possibly help him achieve improvements.

Course of Treatment

Over the course of 7 months Mark participated as a member of a VA-sponsored TFGT that included five other combat veterans and two professional cofacilitators. His group met weekly for those first 7 months and then moved to once a month for booster sessions and transitioning out of the group. For

each session one of the cofacilitators made an outline of the topics to be covered on a flipchart in the group therapy room so that members could refer to the session agenda as the group sessions unfolded. Although it made him somewhat uncomfortable at first, Mark and the other members soon became accustomed to the videotaping of each session. He agreed to the taping on the condition of confidentiality and that the tapes would be used for teaching purposes and to provide feedback to the facilitators for their performances in managing each group session.

It had been many years since Mark and the other members had been assigned school homework. However, he found that doing the weekly assignments prescribed in his own member's workbook made it easier for him to prepare for and follow along with weekly session topics. He also noticed that the cofacilitators had a similar requirement to follow the session guides contained in their own leaders' manuals.

Mark's response to treatment thus far was positive. He attended sessions as scheduled and completed homework assignments on all except one occasion. Since he had been prone to social isolation, it was especially noteworthy that he related well to other members of the group and appeared well motivated to begin his warzone trauma work.

The 13th session was devoted to supporting Mark as he reviewed his specific combat-related trauma in detail (i.e., "exposure") for approximately 45 minutes and then reconsidered his assumptions and beliefs about the event for accuracy (i.e., "cognitive restructuring"), utilizing feedback and observations from both other group members and the facilitators over about an hour. For his exposure work, Mark chose to work on an explosion which occurred when he and three of his buddies were cleaning a bunker. There were two key aspects of the cognitive restructuring in the session: (1) clarifying the exact sequence of events during the trauma; and (2) ascertaining whether the events were predictable or controllable. While Mark clearly believed himself culpable for the injuries of his companions, the data did not necessarily support his assumption of guilt, according to other experienced members' observations. Thus, tension between his evaluations and those of respected others prompted him to begin reconsidering his self-appraisal of responsibility. This "cognitive shift" was accompanied by a drop in his rated anxiety level. This therapeutic work continued in Mark's second round of trauma focus 6 weeks later.

Outcome and Prognosis

Mark attended every session except one and completed almost all of his homework assignments. After years of avoidance (shutting out thoughts about the trauma), he did find listening to the taped narrative of his trauma very stressful (experiencing anxiety levels of 9 or 10 during each exercise),

and reported a significant increase in sleep difficulties and nightmares intermittently during the 8 weeks he did his focused trauma work. As the trauma focus component of the treatment was drawing to a close, he spontaneously played the tape for his girlfriend so that "she could understand what I might have done wrong and why I was so screwed up." She was very supportive about the experience, and this greatly relieved his tension. At that point, Mark decided to go back to his boss, inform him that he had been working on some personal issues, and ask for his job back. The supervisor agreed to rehire him on a probationary status. At the conclusion of the treatment, Mark opted to transition to an anger management class at the Vet Center, in order to "get more control of my wicked temper." While he still met diagnostic criteria for PTSD, his symptom severity had declined approximately 25%. He reported that he had found the TFGT content "somewhat helpful" but was especially appreciative of the feedback from his peers and for the opportunity to bond with other veterans.

INDICATIONS FOR GROUP THERAPY FOR PTSD

Elsewhere we have detailed a number of individual characteristics that have emerged in the literature regarding the appropriateness of choosing group therapy as a primary therapy for PTSD (Foy et al., 2000). Among these factors are the following:

Has ability to establish interpersonal trust with other group members and leaders
Has prior group experience, including 12-step groups
Has completed a preparatory course of individual therapy
Is not actively suicidal or homicidal
Shares similar traumatic experiences with other group members
Has compatible gender, ethnicity and sexual orientation with other members
Is willing to abide by rules of group confidentiality
Is not severely paranoid or sociopathic
Has stable living arrangements

TREATMENT–CLIENT MATCHING CONSIDERATIONS

Since individuals recovering from traumatic experiences often show great emotional volatility and mistrust, a gradual approach has been recommended that involves three phases: (1) education and support, (2) trauma processing, (3) and longer-term reintegration (Klein & Schermer, 2000). It is striking that

these phases correspond closely with the different primary aims of the three types of group treatment in this chapter. We have also enumerated factors related to matching individuals to the three types of evidence-based group therapy (Foy et al., 2000). Developing a comprehensive, effective treatment plan well suited for the individual is of paramount importance. In addition to group treatment, many individuals with severe chronic PTSD and serious comorbid conditions will need ongoing case management services.

Active psychoses, severe cognitive deficits, and pending compensation-seeking litigations may be contraindications for assignment to group therapy (Foy et al., 2000). Since these selection factors are primarily rationally derived, they do not constitute hard-and-fast criteria so much as they represent useful guidelines for informing the matching process. Relative to individual forms of therapy for PTSD, group therapies tend to be more structured and place more rigid requirements upon the individual for participation. There is less flexibility for accommodating individual needs that may arise over the course of therapy in the group format. For some individuals, extreme social interaction anxiety may block beneficial participation in group therapy activities.

When we compare possible selection factors for trauma focus groups to those for supportive groups, there are more stringent requirements for assignment to the "uncovering" modality. Generally, individuals need to be psychologically stable and be willing to undergo reexperiencing of their traumas. Supportive group therapy may be a better match for less stable individuals or for those who do not accept the rationale for personal trauma processing. Assignment considerations for the two types of trauma focus group therapy appear to be very similar. Clear factors for differentiating between assignment to psychodynamic or cognitive-behavioral focus group therapies have not been identified.

SUMMARY

Group therapy has emerged as a widely used treatment for PTSD despite the preliminary nature of the evidence from research evaluating group techniques. Despite methodological limitations that constrain the scientific conclusions that can be drawn, positive treatment outcomes have been reported in most studies, lending general empirical support for the use of group therapy with trauma survivors. While three distinct types or combinations of group therapies are represented in the literature, treatment outcome findings do not presently favor a particular type. Indeed, it may well be that the three types are best used in sequence across recognizable phases of treatment for trauma survivors. At the present time, it is clear that much more research is warranted to identify those techniques and procedures that produce superior outcomes.

ACKNOWLEDGMENTS

The authors acknowledge substantial overlap in authorship and text in portions of this chapter and some sections of a similar chapter (Foy et al., 2000) produced as a group treatment guidelines position paper for the International Society for Traumatic Stress Studies.

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